907 KAR 1:595

MAP-9

PRIOR AUTHORIZATION FOR HEALTH SERVICES

MAP-9 (REV. 12/95)	COMMONWEALTH OF KENTUCK CABINET FOR HUMAN RESOURC KENTUCKY MEDICAID PROGRA OR AUTHORIZATION FOR HEALTH-S	ES M	
1. Med. Assist. I.D. No. 2. Recipient La		3. First Name:	4. M.I.
Ten Digits 5a: Provider Number 6a. Provider Name, Address, and Phone Number 7. Co. # of Recipient			7. Co. # of Recipient
Eight Digits			Residence:
5b. Provider Number 6b. Provider Name, Address, and Phone Number			8. Date of Delivery
			(if already delivered)
Eight Digits			11 D . (D) 1
9. Primary Diagnosis:			11. Date of Birth
10. Secondary Diagnosis:			
Signature of Provider:	Date:	<u>Caucinder</u> for yo	u to receive payment,
the recipient must be eligible on the date of service.			be eligible on the date of
'Check The Medicaid Card,			
12. 13. Procedure/ Supply Description	14. Procedure 15. 16. Usu		
Line No.	Supply Code Units of Customa Service Charges	ary Action A =Appro	
	Service	D=Disappr	
0 1 .			
02.			
03.			
04.			
05.			
06.			
19. HCB and Model Waiver Providers enter Approximate Total Monthly Charge:			
\$			
DO NOT WRITE BELOW THIS LINE 20. Reason For Denial:			
20. Reason For Demai:			
21, Other Comments:			
22. Prior Authorization Number:	23. Approval Dates:	24. Type of Serv 40 DME	ice Authorized:
	From:	41MO D E	L WAIVER
Mailroom Use: 45EPSDT/SPECIAL SERVICE 46 HOME HEALTH			
	Through:	52 H.C.B	
		52 & 53 72 DENT	H.C.B & A.D.C
*Not used by		OTHE	
H.C.B Waiver/Model Waiver Signature of Medicaid/Prior Authorization Respresentative:			
Date:			

Please refer to your billing instructions for the appropriate address.